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GUIDELINES FOR THE CLIENT-CENTRED PRACTICE OF OCCUPATIONAL THERAPY

Report of a Task Force convened by the
Canadian Association of Occupational Therapists and the
Health Services Directorate
Health Services and Promotion Branch

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FOREWORD

In response to a request from the Canadian Association of Occupational Therapists, the Department of National Health and Welfare brought together a group of experts to produce this report entitled GUIDELINES FOR THE CLIENT-CENTRED PRACTICE OF OCCUPATIONAL THERAPY. General guidelines from referral to follow-up and detailed assessment and program planning guidelines are presented in this report. The development of detailed intervention guidelines is scheduled for future work. Hopefully these benchmarks will encourage continuing reexamination of existing practices.

National and provincial professional associations as well as practising professionals across Canada are invited to review these consensus guidelines and send comments to the address given on page ii.

This report is not a statement of federal government policy but constitutes a part of the information base from which policies may be developed. It is hoped that the report will be a valuable guide in practising, planning, setting policy on, and administering clinical activities in occupational therapy. In this way the report may serve to enhance quality of care in health services in Canada.

Further, the intent of these consensus guidelines is not to formally standardize the delivery of services across Canada. It is neither the role nor the mandate of the Department of National Health and Welfare to implement these guidelines. Rather, the department's role is to facilitate the development of a framework of common goals, practices and procedures. Thus, implementation will vary provincially and regionally depending on human and material resources, and on policies and priorities of those provinces and regions.

CONTENTS

MEMBERS OF TASK FORCE

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Dr. David Symington, Director, Department of Rehabilitation Medicine, Kingston General Hospital acted as a corresponding member and representative of the Canadian Medical Association.

SUMMARY

1. The selected literature review revealed three areas on which data could be collected for assessing quality of care. These areas are: structure, process and outcome.

2. The Task Force agreed to develop national consensus guidelines for the practice of occupational therapy that focussed on process.

3. General guidelines were developed for client-centred occupational therapy practice from referral through to follow-up, thereby providing a Canada-wide framework of common goals, practices and procedures.

4. Specific guidelines were developed for assessment and program planning.

5. A conceptual framework was developed, including an occupational performance model.

6. The Task Force recognized the need to develop specific intervention guidelines.

7. The national process guidelines presented in this report are time specific and are relevant to the current practice of occupational therapy in Canada. The acquisition of new knowledge may necessitate the revision of these guidelines.

RECOMMENDATIONS

ON THE BASIS OF THIS REPORT, THE TASK FORCE RECOMMENDS THAT THESE GUIDELINES:

1. be circulated to occupational therapists across Canada to improve the quality of care they provide;

2. be reviewed by individual therapists in order to evaluate their own performance and to plan for their continuing education;

3. be used as benchmarks for the development of program evaluation and peer review;

4. be used in discussions with facility administrators about the practice of occupational therapy;

5. be used as suggested benchmarks in setting up new or remodelled departments for the practice of occupational therapy;

6. be used by provincial occupational therapy organizations to develop standards før practice within their provinces. The application of the guidelines may vary throughout Canada and it is the prerogative of each province to apply the guidelines according to provincial priorities; and

7. be considered by educational programs for use in the development of their curricula.

AND FURTHER THAT:

8. government agencies encourage and support the utilization of these guidelines;

9. the Canadian Association of Occupational Therapists (CAOT) facilitate the formation of study groups to discuss these guidelines and their implications for the profession;

10. individuals, provincial organizations, and CAOT forward comments and suggestions about the guidelines to the Department of National Health and Welfare, to be considered by the Task Force in the development of future guidelines;

11. research be supported on the effectiveness of occupational therapy practices and procedures; and

12. this Task Force continue to work on intervention guidelines.

LETTER OF TRANSMITTAL

CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS
801 EGLINTON AVENUE WEST, SUITE 401, TORONTO, ONTARIO, M5N 1E3 789-2689
ASSOCIATION CANADIENNE DES ERGOTHERAPEUTES

Program in Occupational Therapy
The University of Western Ontario
London, Ontario N6A 5C1

July 11, 1983

Maureen Law, M.D., F.R.C.P.(C)
Assistant Deputy Minister
Health Services and Promotion Branch
Department of National Health and Welfare
Ottawa, Ontario
K1A 1B4

Dear Dr. Law:

It is my privilege to transmit to you the report of the Task Force on Guidelines for the Practice of Occupational Therapy.

The Task Force was established in December 1979 in response to a request from the Canadian Association of Occupational Therapists. The Task Force consists of seven occupational therapists, a geriatrician and one representative each from the Canadian Psychiatric Association, the Canadian Medical Association and the Department of National Health and Welfare.

The report presents a conceptual framework for occupational therapy, Canada-wide general guidelines for practice, and specific guidelines for assessment and program planning. These consensus guidelines which are unanimously supported by the Task Force, represent the completion of Stage 1 of the project. The Task Force recommends that Stage 11 be initiated to develop detailed intervention guidelines.

I thank the members of the Task Force for their invaluable contributions and support. I especially thank Mrs. Eve Kassirer, Medical Sociologist, Institutional and Professional Services Division, for her encouragement and expert advice throughout this project. The leadership and support of the Department of National Health and Welfare is greatly appreciated.

Yours sincerely,

Thelma Gill

Thelma Gill, M.Ed., BSc.O.T., O.T.(C)
Chairman, Task Force on Guidelines for the
Practice of Occupational Therapy

ESTABLISHMENT OF TASK FORCE

In 1979 the chairman of the Council of Practice of the Canadian Association of Occupational Therapists learned that funding was available from the Department of National Health and Welfare (DNHW) for professional organizations wishing to develop guidelines for practice. Subsequently a group of occupational therapists was formed to work with a representative from DNHW. These therapists were chosen on the basis of geographic distribution as well as area of specialization and active involvement in the profession. On request, the Canadian Psychiatric Association and Canadian Medical Association each appointed a representative to this group. Thus, a Task Force was established to develop guidelines to improve quality of care in occupational therapy.

COMPOSITION AND REPRESENTATIVENESS OF TASK FORCE

The 11 members of the Task Force include seven occupational therapists, one psychiatrist, one geriatrician, one physiatrist and one medical sociologist. The psychiatrist is a representative of the Canadian Psychiatric Association. The physiatrist, a corresponding member, is a representative of the Canadian Medical Association.

The characteristics of the Task Force with regard to region, sex, and occupational setting are portrayed below.

CHARACTERISTIC	MEMBERS #
REGION	
Eastern Canada	1
Central Canada	7
Western Canada	3
SEX	
Female	8
Male	3
OCCUPATIONAL SETTING	
Academic	3
Hospital	4
Community	2
Government	1
Professional Association	1

TERMS OF REFERENCE

The Terms of Reference as agreed to by the Task Force at its meeting in December 1979, are as follows:

I To develop guidelines for holistic practice in occupational therapy by:

(a) determining types of services required by patients;
(b) identifying areas of practice for which guidelines are needed;
(c) reviewing existing guidelines/standards in Canada and other countries;
(d) arriving at a consensus on the appropriateness of existing measures and new guidelines; and
(e) arriving at a conceptual approach which is applicable to the profession.

II To prepare a review report including guidelines for practice, development of programs and future activity.

GLOSSARY OF TERMS USED IN THIS REPORT

For the purposes of its deliberations the Task Force defined the following terms associated with quality of care assessment as they would apply to occupational therapy.

ACTIVITY	A specific action, function or sphere of action that involves learning or doing by direct experience. (Reed and Sanderson, 1980)
ANOMIE	A state of an individual in which normative standards of conduct and belief are weak or lacking. It is characterized by a lack of purpose, social isolation and problem of identity.
ASSESSMENT	The process of collecting, analyzing and interpreting information, obtained through observation, interview, record review and testing.
CLIENT	A recipient of occupational therapy services.
COGNITION	The process of knowing or perceiving information.
COMMUNITY-BASED	The delivery of occupational therapy services in settings other than hospitals/institutions, eg: schools, day care.
COMPETENCE	The knowledge, skills, values and attitudes needed to properly carry out one's professional activities. (Butler, 1978)
COMPETENCY	The ability to perform skills to the level of efficiency required by physical, psychological and social health.
EFFECTIVENESS	The average benefit of a procedure when used by the average provider in the average community. (Rosenthal, 1977)
EFFICACY	The benefit (or lack of it) of a procedure or treatment when performed under ideal circumstances. (Rosenthal, 1977)
EFFICIENCY	The ratio of useful work performed to the total effort expended. (Rosenthal, 1977)
EVALUATION	A testing procedure.

FUNCTIONAL ASSESSMENT	An evaluation of the integration of mental, physical, sociocultural, and spiritual states and their interaction in order to perform purposeful acts.
GOAL	The purpose or aim of a client's program or therapist's activities.
GUIDELINE	An outline from which standards or criteria can be developed to measure quality of care.
HOLISTIC	The perception of the client as a whole person; the overall state of health being interpreted as a result of a complex interaction of factors which includes mental, physical, sociocultural and spiritual components.
HOSPITAL/ INSTITUTIONAL-BASED	The delivery of occupational therapy service in an institutional setting.
INDIVIDUAL	A person viewed as having distinct characteristics.
INTRAPERSONAL	The individual characteristics involved in the relationship within one's self.
INTERPERSONAL	The factors involved in relationships between persons.
LEISURE	The components of life which are free from work and self-care activities.
MEDICAL MODEL	A structure of information including treatment approaches based on disease classifications defined by the medical profession.
MIND	An entity which, though lacking a physical or material reality, is nevertheless credited with the facilities of thinking, willing and feeling.
MOTOR	The production of motion by a muscle, nerve or centre that affects movement.
OBJECTIVE	A specific, measurable activity designed to achieve a goal.
OCCUPATIONAL PERFORMANCE	Activities carried out by the client in the areas of self-care, productivity and leisure influenced by environmental and societal factors. (Reed and Sanderson, 1980)

OCCUPATIONAL THERAPY	Occupational therapy is the art and science which utilizes the analysis and application of activities specifically related to occupational performance in the areas of self-care, productivity and leisure. Through assessment, interpretation, and intervention, occupational therapists address problems impeding functional or adaptive behaviour in persons whose occupational performance is impaired by illness or injury, emotional disorder, developmental disorder, social disadvantage, or the aging process. The purpose is to prevent disability; and to promote, maintain or restore occupational performance, health and spiritual well-being. Furthermore, occupational therapy services can be directed through health, educational and social services systems.
OCCUPATIONS	Activities or tasks which engage a person's resources of time and energy; specifically self-care, productivity and leisure. (Reed and Sanderson, 1980)
OUTCOME	The empirical result of administered care. (DNHW and Canadian Physiotherapy Association [CPA], 1980)
PEER REVIEW	Formal assessment by a colleague in the same profession. (DNHW and CPA, 1980)
PROCESS	The nature and sequence of actions and interactions (dynamic) of administered care. (DNHW and CPA, 1980)
PRODUCTIVITY	Those activities or tasks which are done to enable the person to provide support to the self, family and society through the production of goods and services. (DNHW and CPA, 1980)
QUALITY ASSESSMENT	Involves measuring the level of quality provided at some point in time; it connotes no effort to change or improve that level of care. (Rosenthal, 1977)
QUALITY ASSURANCE	Involves both measuring the level of care provided and when necessary improving it. (Rosenthal, 1977)
QUALITY OF CARE	The degree of excellence in the provision of services.

REFERRAL	A request to an occupational therapist for advice or decision regarding client services.
SELF-CARE	Those activities or tasks which are done routinely to maintain the person's health and well-being in the environment. (Reed and Sanderson, 1980)
SENSORY	The appreciation of sensation caused by stimulation of a sense organ.
SKILL	The ability to demonstrate one's knowledge effectively.
SPIRITUAL WELL-BEING	A state of well-being; the force that permeates and gives meaning to all life.
SOCIOCULTURAL	The dimension which describes the interpersonal relationships of a person with reference to his family, education, ethnic and community background.
STANDARD	Officially established level and its acceptable degree of variation. (DNHW and CPA, 1980)
STANDARDIZED TEST	A tool in which specific instructions and materials are used to evaluate a measurable behaviour, with a system for recording and scoring to allow comparison with a norm.
STRUCTURE	Organized patterns of social, economic, environmental, physical and human resources that create a milieu for health care. (DNHW and CPA, 1980)
TASK	A specific activity or job which is to be performed. The function that a working person is expected to fill. (Reed and Sanderson, 1980)

CHAPTER I: INTRODUCTION

Since the late 1960s, several factors have made it imperative for health care professionals to look critically at the manner in which health care is delivered in Canada. Some of these factors follow:

The increasing prevalence of chronic disease and the need for individuals to accept a greater responsibility for their own health.

The proliferation of technological advances in investigation, diagnosis and treatment now available to health care professionals.

The heightened sophistication and effectiveness of mass communication techniques which have resulted in a more astute and critical consumer population.

The acceleration of adaptive changes now occurring in many of the human service areas with the resulting emphasis on health maintenance, prevention and early disease detection.

The insurgence of economic concern by governments about the ever-increasing high cost of health care which will dictate greater accountability of the service delivery by health care professionals.

Occupational therapy as an evolving health care profession practised in traditional hospital settings, community agencies and private practices, has recognized that these factors must be addressed.

The essence of occupational therapy practice is the engagement of clients in purposeful activities designed through the integration of the art of healing and scientific methods.

The quality of this practice is a critical issue, including professional concerns such as competency, accountability and ethics. With the focus in recent years on evaluating health care delivery it is important that a consistent method of occupational therapy assessment be developed. Therefore, in this report the Task Force provides procedures for increasing the quality of occupational therapy care in Canada.

Since quality assessment and quality assurance are emerging as crucial issues in health care, a clear understanding of their different components is essential. Assessing the nature of care usually implies a comparison either with established criteria or with services of the same type provided by others in the same field of activity. Quality assessment clearly sets out to establish the degree or grade of excellence of the services provided. Quality assurance takes quality of care one step further by not only assessing health care delivery but committing to evaluate and improve care. The focus of this document is on quality assessment.

1. HISTORICAL BACKGROUND: DEVELOPMENT OF QUALITY OF CARE IN OCCUPATIONAL THERAPY

Four Activities of the Canadian Association of Occupational Therapists (CAOT) to Establish Guidelines for Occupational Therapy

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In 1966 in cooperation with Statistics Canada and the Department of National Health and Welfare, CAOT developed a unit value statistical system to apply uniformly throughout Canada. The main objective of this national system is to record and report the utilization of occupational therapy services. With the collection of these data and other available information, the degree of involvement in patient care can be determined but not the quality of that care.

In 1973 CAOT approved a document outlining the standards for occupational therapy services which was subsequently utilized by the Canadian Council on Hospital Accreditation in its "Guide to Hospital Accreditation" (CCHA, 1977). CAOT has recently updated the standards to reflect changing trends in the provision of occupational therapy services - "Standards for Occupational Therapy Services" (CAOT, 1982). These standards outline structure criteria which can be used to assess occupational therapy facilities, record-keeping procedures, and professional qualifications of occupational therapists providing services within health care institutions.

The identification of competencies required by an occupational therapist was initiated in 1977 by a CAOT task force. In 1980 the project to develop the Occupational Therapist-Occupational Profile was completed and rated to identify the competencies required of entry level occupational therapists with a baccalaureate degree. The task force's recommendations were approved by CAOT and precipitated revisions to the "Standards For the Education of Occupational Therapists in Canada", (CAOT, 1980).

In 1979 CAOT approached the Department of National Health and Welfare (DNHW) for assistance in developing additional guidelines for practice. The term guidelines, as opposed to standards, is significant in this project, as guidelines imply outlines, suggestions or benchmarks which may be modified and developed into standards. Guidelines are not formulas; they do not take the place of professional judgment. As well, it is not within the jurisdiction of the federal government to create standards for health care. It is the responsibility of the provincial occupational therapy organizations to implement and monitor their own standards.

The DNHW Task Force realized the complexity of this project; history records the difficulty in developing guidelines that are valid, relevant, feasible, and realistic in their application to all regions of Canada. Moreover, the Task Force recognized that these guidelines must be reasonable as opposed to optimal or minimal.

2. A REVIEW OF QUALITY OF CARE MEASURES

The Task Force selectively reviewed the literature on health care evaluation to determine methods used by various health care professions to measure quality of care. The group concurred with and adapted the classic work of Donabedian (1966), which conceptualized three major areas to be assessed and on which data could be collected.

- MEASUREMENTS OF STRUCTURE for assessing the adequacy of the facility, qualifications of staff, and the equipment available to provide care.

- MEASUREMENTS OF PROCESS for assessing the use of referral, assessment, program planning, intervention, discharge, follow-up and record-keeping procedures for client-centered services.

- MEASUREMENTS OF OUTCOME for assessing the results of client centered services in promoting effective change in the client's functional status.

These measurements can be applied to assessment methods and documents most commonly used by occupational therapists in evaluating quality of care.

- Peer Review
  Measures the therapist's skills in devising and implementing a treatment program, and the results of that program. (Process and/or outcome measures)

- Chart Audit (review of the client's medical records)
  Examines what care was given and what the recorded results were. (Process and/or outcome measures)

- Accreditation Standards
  Devised by the professional organizations (e.g. The Canadian Council on Hospital Accreditation and the Canadian Association of Occupational Therapists) for assessing occupational therapy facilities. (Structure measures)

- Occupational Therapist - Occupational Profile
  Developed by the Canadian Association of Occupational Therapists in 1980 to rate the skills of an entry level occupational therapist. (Structure measures)

- Occupational Therapy Profile Guidelines - Québec
  Developed in conjunction with the Department of Labour and Manpower and the Corporation Professionnelle des Ergothérapeutes du Québec (CPEQ) as an analysis of occupational therapy tasks. (Process measures)

- Continuing Competency Project - American Occupational Therapy Association (AOTA)
  Proposed by AOTA in 1976 to delineate a methodology to establish standards of job performance and continuing education opportunities for maintaining competency of occupational therapists. (Structure measures)

As well, the Task Force reviewed the literature and explored selected methods, primarily process measures, used by other health care professions. Since methods used did not apply to occupational therapy, the first step was to delineate quality assessment guidelines unique to Canadian occupational therapy. The Task Force agreed not to concentrate on structure guidelines which already exist as accreditation standards and as skills profile criteria.

3. SELECTION OF PROCESS GUIDELINES

After considering both process and outcome approaches, the Task Force decided to follow the process approach, because process guidelines are a priority for the profession. This priority is based on the desire for nationally-shared benchmarks for the practice of occupational therapy. Process guidelines would be the first step in identifying and describing the sequential interaction of events of the client with the occupational therapist (from referral to discharge/follow-up). With the recognition that individuals have primary responsibility for their own health, the guidelines have been developed from a client-centred perspective. (See Chapter III.)

Subsequently, detailed assessment and program planning guidelines were developed; intervention guidelines were scheduled for development as the next project.

A future step might be to develop outcome measures for occupational therapy. The results of intervention are often produced by a multidisciplinary approach, leading to difficulty in measuring the effectiveness of occupational therapy.

4. KNOWLEDGE AND SKILLS

Education

The curriculum of the first Canadian program in occupational therapy, offered at the University of Toronto in 1918, included classes in anatomy as well as the manual arts. From this six week certificate course, the education of the occupational therapist has developed into a baccalaureate program. There are now 10 universities across the country offering programs, all accredited by the Canadian Association of Occupational Therapists (CAOT). Accreditation is a rigorous process which requires detailed documentation of the curriculum as well as an onsite visit.

All accredited occupational therapy curricula provide core courses in the medical sciences, behavioural and social sciences, as well as applied professional course content. Students study such courses as child development, personality and learning theory as well as research methodology. Courses outside the professional area are usually taken on campus with other university students, and taught by specialists in those fields. Resulting theories and concepts are then integrated into occupational therapy courses. These courses focus on the use of developmentally appropriate tasks and activities in assessment and intervention of occupational performance and its components.

In addition a minimum of 1200 hours of fieldwork in CAOT approved or accredited facilities must be completed. These may be in hospital settings, extended care settings, community facilities, or special programs offered within an educational model. There must be a balance of the time spent in physical and mental health settings.

Body of Knowledge

Purposeful activity and activity analysis are fundamental to interventions used to promote occupational performance. Emphasis is placed on the occupational therapy process involving assessment, planning, implementation and termination of interventions (Cynkin, 1979).

The use of activities of interest to clients, and those which enhance their abilities to perform tasks appropriate to their health status and resources, form the core of occupational therapy's specialized subject matter.

Biological, behavioural, and social sciences and their specific application to the client's functional needs provide a unique orientation to the health field. Additional knowledge includes the impact of the disease process, physical and mental health, as well as mechanisms of adaptive functioning. Links between body, mind, spirit, and society assist the therapist in choosing (according to accepted theory) the appropriate media and methodology to realize therapeutic goals.

Skills and Approaches

In assessing and treating occupational performance throughout a life span, occupational therapy utilizes a holistic orientation and purposeful engagement relative to a variety of activities. This requires the integration of all knowledge areas to increase the functional capacity of clients. Those ordinary activities of everyday living, so routinely done, (such as dressing, making a bed, taking a shower, typing, taking a bus) become the therapist's focus in performing functional assessments. Task demands are analysed for their physical, social and symbolic implications. This knowledge becomes synthesized and a viable professional intuition evolves to enhance the skills of the therapist (Albright and Albright, 1980).

Fundamental to the therapeutic relationship is the understanding of the use of self. This is the conscious use of the therapist as an agent of change and a potent factor in the occupational therapy process. The therapist's personal response to the client can affect the direction of the client's progress.

The therapist's ultimate objective is to establish an appropriate balance between the time spent by the client in activities of self care, productivity, and leisure. Although clinical observation, problem solving and activity analysis skills are essential components of the therapist's effectiveness, these cannot be viewed separately from the context in which they are applied; from the client who is the focus; or from the specific dysfunctions which occupational therapists must address (Cynkin, 1979; Mosey, 1980). Thus the occupational therapy approach is unique rather than the specific skills used by the therapist. It is this that constitutes the art of therapy (Moore, 1977).

5. ETHICS

A professional code of ethics is "an implicit promise to society to uphold standards of technical and moral competence" (Purtillo and Cassel, 1981, p.20). The Canadian Association of Occupational Therapists has adopted a code of ethics which identifies areas of responsibility to the consumer, self, profession, colleagues, employing agency and community. This national code is the one most frequently utilized by provincial occupational therapy organizations.

CHAPTER II: CONCEPTUAL FRAMEWORK

A conceptual frame of reference provides a systematic and consistent approach to classifying, and analysing behaviour and activities. The Task Force has adopted a conceptual framework which integrates a number of theoretical and philosophical concepts followed by occupational therapists. These concepts have been developed from professional experience and perceptions of Task Force members; and from a review of literature in occupational therapy, health care, systems theory and developmental theory. (See for example: Reilly, 1962; Duval, 1966; Schvaneveldt, 1966; Wantanabe, 1968; Reilly, 1969; Llorens, 1970; Clark, 1979 a, b,; Mosey, 1980; Kielhofner and Burke, 1980). Most occupational therapists have traditionally incorporated some of these key concepts in their professional practice. However, there is often a tendency to separate concepts from their origins and to use them in an isolated manner in practice. This results in a loss of the meaning and value of science and creates dependency on a procedure that can be neither adapted nor changed.

Occupational therapists have long adhered to a belief in the worth of the individual, a holistic approach to health care, and a frame of reference which utilizes normal or adapted activity for therapeutic purposes within a therapeutic relationship. Many of these concepts have been described in occupational therapy textbooks and in other literature. They are summarized in this chapter to suit the Canadian context and to reflect growing trends for the present and future practice of occupational therapy across the nation.

A conceptual frame of reference is an integrated presentation of basic assumptions, principles and key concepts. Its application requires an interpretation of its elements according to the particular model of practice. For analytical purposes the following concepts are reviewed separately and summarized as they apply to occupational therapy.*

1. WORTH OF THE INDIVIDUAL

2. HOLISTIC VIEW OF MAN

3. OCCUPATIONAL PERFORMANCE MODEL

4. THERAPEUTIC USE OF ACTIVITY

5. DEVELOPMENTAL PERSPECTIVE

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* Persons wishing to review the general theoretical framework of these concepts specific to the fields of health care, human services, systems theory, or other fields, are directed to the References and Selected Bibliography at the end of this Report.

1. WORTH OF THE INDIVIDUAL

A belief in the worth of the individual is the underlying premise of all occupational therapy practice. By accepting that man is a complex entity, with many spheres and a unique capacity to interpret, mediate and act, occupational therapy is concerned with providing functional experiences which enhance self-worth in a way which assists individuals to reach their potential. The individual is an active participant within this therapeutic relationship.

2. HOLISTIC VIEW OF MAN

Occupational therapy acknowledges and practises within a humanistic view of the individual as a whole person. Man is viewed as an integrated being in which no area of function can be isolated as a separate entity, but viewed as part of the total makeup of the individual.

Holistic concepts have always been fundamental to the beginnings of occupational therapy. Early literature identified the mind, body, and spirit as the interacting elements in therapeutic activities provided to soldiers who returned from World War I. This basic philosophy was depicted graphically in a triangular badge designed for the "ward aides", the first Canadian occupational therapists (Trent, 1919). Thus, present practice has evolved from that originally defined need to provide therapeutic occupational activities to assist soldiers in returning to work.

3. OCCUPATIONAL PERFORMANCE MODEL

A graphic model of occupational performance, based on the perception of the interacting spheres of the individual is presented in Figure 1 below.

Occupational therapists view man's occupational performance as having three areas: self-care, productivity and leisure, predicated on the interaction of the individual's mental, physical, sociocultural and spiritual performance components (Reed and Sanderson, 1980).

Occupational therapists practise within a model which accepts the premise that man has a need to be engaged. His engagement takes many forms and roles, each having a crucial effect on his quality of life. The culmination of man's experiences in this conceptual model is the formation of the individual's mental, physical, sociocultural and spiritual self. The essence of a healthy, functioning person is the balanced integration of these four performance components to provide a sense of well-being. Man integrates these components by engaging with social, cultural, and physical aspects of the environment which he affects and by which he is affected.

Activity and interaction stimulate the central nervous system in multiple ways, producing in man a dynamic, constantly changing system.

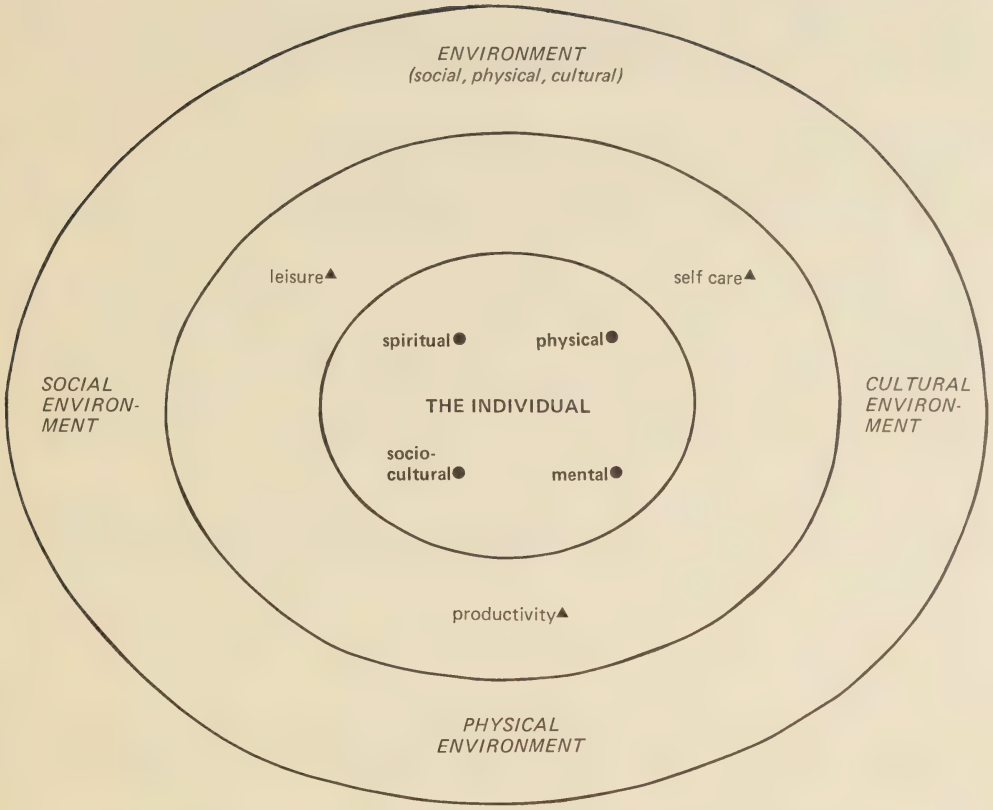

FIGURE I INTERACTING ELEMENTS OF THE INDIVIDUAL IN A MODEL OF OCCUPATIONAL PERFORMANCE■

● Performance components
▲ Areas of occupational performance
■ Adapted from Reed and Sanderson, 1980

The mental component includes cognitive, affective and volitional functions. Mentally, man has the capacity to reason and to adapt. Through interaction with the environment and with people, man develops a sense of self. He stores and transmits symbols which allow him to interpret the world and be both actor and reactor within it (Schvaneveldt, 1966; Clark, 1979a). Man's responsibility for self evolves to provide the capacity to direct his own life.

The physical component encompasses motor and sensory functions (Reilly, 1962). In this component, man satisfies needs for food, safety, sex and self-care. Through refined manual skills, he increases his potential to engage in activity.

In the sociocultural component man's behaviour patterns are determined by his set of beliefs, value system, developmental stage and life situation. His value system provides him with a blueprint for normative behaviour. If a value system is absent anomie results (Solomon, 1980). During interaction with others, man is stimulated to experience emotions and feelings.

As a spiritual being, man is concerned with nature, the meaning of life and his purpose and place in the universe. This component has not been identified in the previously cited American occupational therapy literature but has been one of the fundamental elements in the conceptualizing of Canadian occupational therapy practice (Trent, 1919; Smith, 1964). Its inclusion here represents a reintegration with occupational therapy practice and current trends in health care literature (Albright and Albright, 1980; Gordon, 1980).

Occupational performance is conceptually complex. Its rating is based on the analysis of the level of functioning of the performance components, the required developmental skills and the relevance of the behaviours to the role requirements of the client.

4. THERAPEUTIC USE OF ACTIVITY

Occupational therapy uses activity analysis and adaptation in selecting activities or occupations, to fulfill defined therapeutic goals. This use of purposeful task engagement (a therapeutic strategy) is the essential uniqueness of occupational therapy.

The role of the occupational therapist is to facilitate the individual's engagement with his environment. An essential component of the therapeutic relationship is the therapist/client interaction and the exchange which occurs throughout the learning situation created by the occupational therapist. Purposeful activity is used to develop and refine task skills, to explore alternative roles and to promote positive change in areas of occupational performance.

5. DEVELOPMENTAL PERSPECTIVE

Therapists consider the individual's occupational performance within the context of a life stage. Throughout the life span, occupation has different primary purposes. In each stage of development, the individual's progress is affected by the status of his performance components (functional/dysfunctional) and the social, cultural and physical elements of the environment.

Within the lifespan five major developmental stages emerge, which provide a structure to view a client's occupational performance.

These are the following:

childhood (birth to puberty)
adolescence (puberty to 20 years)
young adulthood (21-35 years)
middle years (36-65 years)
the mature years (over 65).

CHAPTER III: GENERAL GUIDELINES FOR CLIENT-CENTRED OCCUPATIONAL THERAPY PRACTICE

In this chapter general guidelines are developed for client-centred occupational therapy from referral through to follow-up. Specific assessment guidelines and program planning guidelines are provided in Chapters IV and V. Specific intervention guidelines have not been addressed in this report but will be in a future document.

The general guidelines in this chapter and Appendix B give practitioners and administrators a Canada-wide state-of-the-art framework of common goals, practices and procedures in occupational therapy. Thus, some uniformity and consistency in service delivery can be assessed across Canada.

These guidelines have been deliberately set in a simple format. The Task Force does not intend to provide a formula for client care; rather, to provide national benchmarks with which practitioners can build therapy programs. The creative aspects of occupational therapy may still be reflected in the array of treatment approaches, intervention models and professional styles, relative to client needs.

Increased professionalization accompanies increased consensus in practice.

This discussion of the guidelines does not include the client-therapist relationship. The therapeutic relationship cannot be seen only as one step in the system; it is implicit to the entire exercise and as such pervades every step. Until rapport is established, with open or tacit agreement on the part of the client to proceed, i.e. informed consent, there can be no occupational therapy. The relationship as well as treatment must be initiated, developed and terminated.

Although observation and activity analysis are components of the therapist's effectiveness, these cannot be viewed separately from clients who are the focus; or from their specific dysfunctions.

The content of this chapter has been structured as follows.

1. STAGES OF PRACTICE
2. OCCUPATIONAL THERAPY PROCESS: SYSTEMS APPROACH
3. GENERAL GUIDELINES FOR STAGES OF PRACTICE

The guidelines have been set out in steps which proceed temporally from the client's point of entry into the therapeutic system until his final exit. Not every client will go sequentially from the first step to the final one. Contact may be terminated at varying intervals: after screening, assessment, or on discharge from a therapeutic program. This presentation represents potential steps of a continuum through which clients may proceed.

The guidelines have been written in very general terms to permit adaptation to a particular service setting. For example, referral guidelines establish a need for a formal referral procedure. In some provinces legislation may require that an occupational therapist have a physician's referral; in a particular institution or facility, policy may dictate a medical referral; an occupational therapist working within the school system may require a psychologist's referral; an occupational therapist working in the community may accept a client-initiated referral.

The need for documentation of findings at each stage cannot be stressed enough. These requirements should be established by each setting or facility and time intervals should be set down for their completion. For example in an acute care setting the general assessment may need to be completed within 24 to 48 hours following receipt of the referral; in a long-term care facility this same time may be unrealistically short.

Before standards or guidelines are set down provincial statutes governing the practice of occupational therapy should be explored. In turn occupational therapy standards should be compatible with those set by the work facility. If third party coverage for occupational therapy exists special considerations with respect to guidelines may need to be given.

1. STAGES OF PRACTICE

The delivery of occupational therapy services as a client-centred process which considers clients as part of their environment can be conceptualized within a systems approach. (See Figure II) This approach is chosen to illustrate that the occupational therapy process is based not only on the personal experience of the client but also on his social reality. It also shows the relationship of the process with the care-giving professional.

In this perspective, the system is the occupational therapy process. The client enters the system via referral by a health professional or by self referral. Information accompanying entrance to the system is used within the process, along with information generated by the development of the process and by significant others in the environment. Usually the therapist guides the client through each appropriate stage (subsystem) until his discharge and return to society. The stages are identified as described below.

(a) Referral

The referral stage includes the screening of individuals who would benefit from occupational therapy intervention by determining appropriateness or eligibility, as well as obtaining the completed referral.

Each department, service, facility or practitioner may set eligibility criteria or these may be imposed to some degree by legislation, hospital policy or management practices.

Certain key data are required for an acceptable referral. The content of the referral should be developed by each service. Its contents should include relevant client data with background information and some description of the problem(s) for which intervention is sought.

(b) Assessment

The assessment stage begins with data collection. This data base is collected from several sources (patient, family, other professionals, community agencies) and in various ways (interview, observation, completion of standardized instruments). Other components of assessment include: analysis and interpretation of data; problem identification; recommendation for occupational therapy services (or return to referrant); and communication of the assessment results to clients, team, family, or other relevant agents.

The occupational therapy service should have sufficient resources to supply a number and variety of assessment tools. These may be generic and/or specialized instruments which are either standardized or non-standardized. As the practice of occupational therapy has developed and specialized so have the available tools. (See Chapter IV)

(c) Program Planning

This stage refers to the tasks of reviewing and analyzing assessment data, and developing a strategy for intervention, encompassing what to do, in what order, and when. For example: create an environment suitable for intervention; determine aims of intervention; select the appropriate approach, theoretical frame and methods of intervention; select and/or adapt activity; design a schedule; and discuss plans with client, team, and family. Discharge plans and other contingencies (eg. referral to community agencies or other services) should be outlined during this stage. (See Chapter V).

(d) Intervention

Intervention is the implementation of the planned program of care. As intervention is a dynamic process, there is a need to review the client's progress towards goals, and to modify the program plan as needed. Intervention requires the therapist to motivate the client according to the nature of the problem, to his expectations stemming from his set of values, and to the aims of intervention; to develop, maintain or restore function; to educate whenever necessary; to re-evaluate the client; and to prevent the occurrence of further or other functional problems.

(e) Discharge

Discharge refers to the formal termination of active intervention. Discharge may take place as a natural course of events; the client may have derived maximum benefit from the program or discharge may be due to other circumstances (eg. poor patient motivation, emergency care).

(f) Follow-up

Follow-up is not always possible as part of an occupational therapy program but it is a valuable adjunct to care. Follow-up provides a method for monitoring whether the client is being maintained at an optimal level of functioning. If difficulties arise following discharge, they may be identified at that time and intervention reinstituted. The client can then reenter the therapeutic system for readjustment of functional capacities better able to maximize his skills to meet the demands of the environment by experimenting with his newly-acquired autonomy.

(g) Program Evaluation

Program evaluation is not always routine. It may be conducted on an individual case or broader basis according to prescribed criteria; or via a more formalized review (chart audit, peer review, client satisfaction survey, quality assurance program). This may not immediately follow discharge or follow-up, but may be part of a planned periodic review.

It is vital that occupational therapists examine both the process and outcome of their interventions in order to provide clients with a high quality service, with up-to-date effective treatment modalities.

2. OCCUPATIONAL THERAPY PROCESS: A SYSTEMS APPROACH

Figure II provides a graphic illustration of a suggested blueprint for occupational therapy process, using a systems approach wherein feedback permits constant adaptation on the part of clients, therapists and environments.

As Figure II shows, the client travels in the system along the striped arrows between each completed stage (subsystem) and out to the environment; other routes are also possible along the solid arrowed lines. For example, a client may go from identification of the problem back to the referrant or to society; or back from reassessment to one or another level of the assessment subsystem, or to redetermination of modified aims of intervention.

The information which will potentially affect the process at any level of any stage (subsystem) is slotted in along the dotted line arrows, which means that the occupational therapist constantly incorporates information from the environment to use within the process. In this feedback system the process is thus adapted both to the needs of the person and to the demands of the environment, with which the client chooses to comply. Thus, occupational therapy services can be viewed as an open system in constant interaction with the environment, receiving and giving information, taking into account family, school, work, and community.

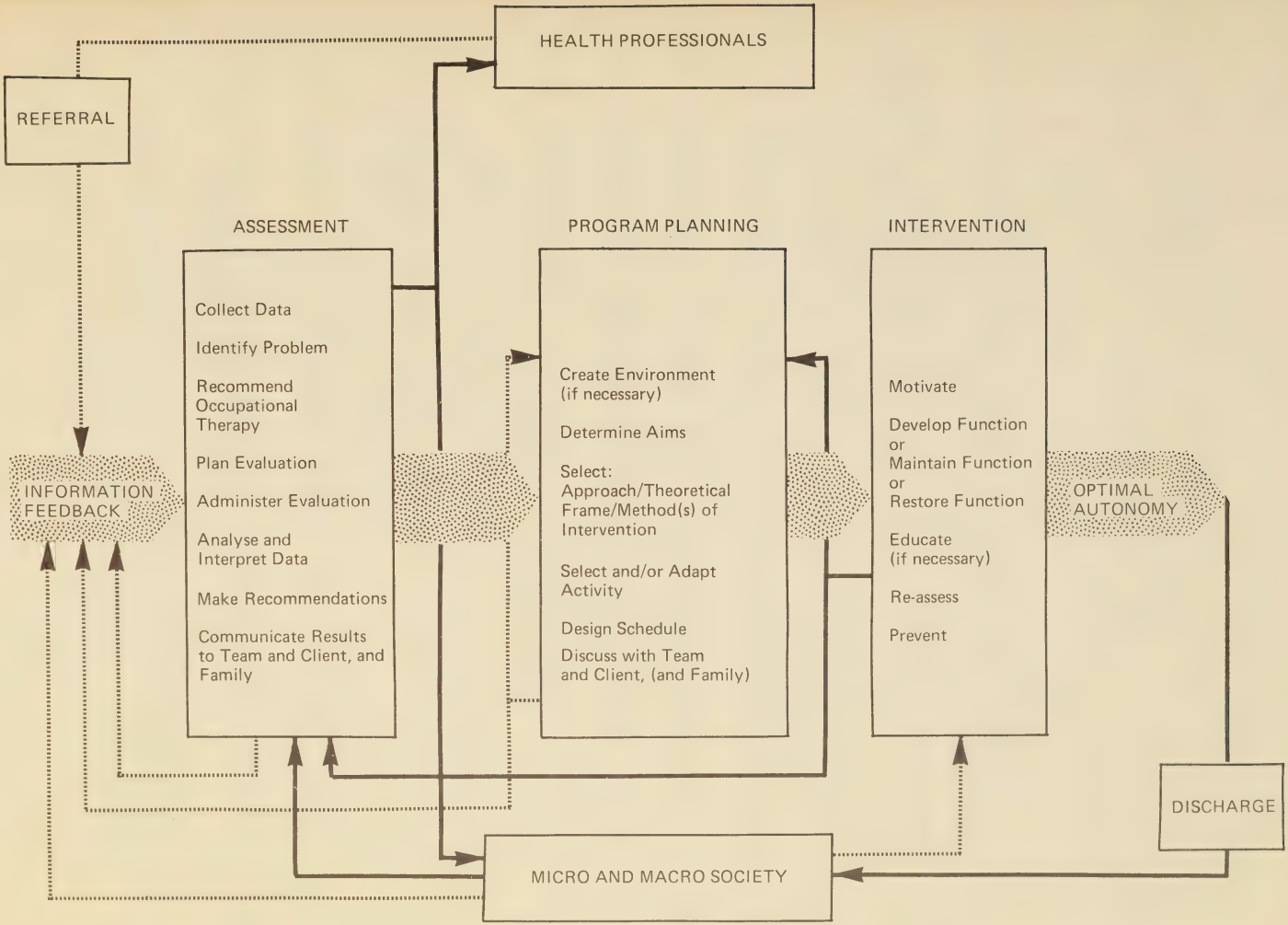

FIGURE II OCCUPATIONAL THERAPY PROCESS: A SYSTEMS APPROACH

3. GENERAL GUIDELINES FOR STAGES OF PRACTICE

In the preceding sections, a profile has been presented of the stages the client moves through in receiving occupational therapy services. General guidelines relative to these stages follow. Further in the text specific details are provided relative to two key elements of care: assessment (Chapter IV) and program planning (Chapter V).

(a) Referral Guidelines

(i) The therapist should receive a referral from an authorized source in accordance with the policy of the service.

(ii) The therapist should determine the appropriateness of the referral and the eligibility of the individual for an occupational therapy program. This may be done in an interview or by review of records.

(iii) When the referral is received the therapist should document:

- the date of receipt;
- referral source; and
- the kind of services requested.

(iv) If the referral is appropriate, the therapist should undertake a general assessment of the individual.

(v) If the referral is inappropriate, the therapist should recommend alternatives to the referral source.

(vi) The documentation should be done within a time frame that is in accordance with the policy of the service.

(b) Assessment Guidelines

(i) The therapist should gather data and outline the purposes of the assessment.

(ii) The therapist should obtain additional relevant information regarding history, education, work records, family, from the individual and family/significant others.

(iii) This global assessment should include an evaluation and documentation of the individual's abilities and deficits in the following areas:

occupational performance areas
- self-care
- productivity
- leisure

performance components
- mental
- physical
- sociocultural
- spiritual

environment
- physical
- social
- cultural

The therapist should document occupational performance and determine if more detailed and specific evaluation is required.

The therapist should ensure complete assessment either within the service or by referral to other professionals.

(iv) The therapist should analyse the assessment data, formulate impressions of the presenting problem(s) and make recommendations.

(v) This assessment should be documented within a defined time interval following receipt of the referral.

(c) Program Planning Guidelines

(i) The therapist should determine and document a program plan consistent with the assessment data and the recommendations obtained in the assessment.

(ii) The program plan should be developed to include a:

- statement of measurable goals both short-term and long-term;
- selection of a theoretical approach/frame of reference appropriate to the individual's needs;
- selection of methods of intervention;
- schedule for the implementation of the plan;
- tentative discharge plan; and
- evaluation schedule.

(iii) The program plan goals and methods must be developed in conjunction with:

- goals of the individual and/or family;
- program plans of other professionals; and
- available resources (institutional and community).

(iv) The program plan should be developed within a defined interval following completion of the assessment.

(d) Intervention Guidelines

(i) The therapist should implement the program according to the program plan.

(ii) The therapist should document the occupational therapy services provided and the individual's progress toward the goals at a frequency recommended by the service.

(iii) The therapist should regularly (or as determined by the service) reevaluate and document changes in the individual's occupational performance and the performance components of those skills.

(iv) The program plan should be modified in accordance with these changes.

(v) The therapist should communicate at regular intervals (or as determined by the service) with other involved professionals and family/significant others;

(vi) The therapist should review and refine the discharge plan.

(e) Discharge Guidelines

(i) The therapist should terminate services when the individual has achieved the goals or when maximum benefit has been derived from occupational therapy services.

(ii) A discharge plan should be finalized and documented.

(iii) The plan should be consistent with:

- the individual's functional abilities and deficits, goals, prognosis, and community resources; and
- the discharge plan of other involved professionals.

(iv) Time should be allocated for the coordination and effective implementation of the plan.

(v) The therapist should document a discharge summary in accordance with the policies of the service. This could include the individual's functional status, goal attainment, unmet goals, plans for ongoing services and further recommendations.

(vi) The client - therapist relationship should be terminated.

(f) Follow-up Guidelines

(i) The therapist should reevaluate the individual at an appropriate time interval following discharge.

(ii) The reevaluation results should be documented.

(iii) If the individual requires further service, the therapist should refer to the service needed.

(g) Program Evaluation Guidelines

(i) The therapist should evaluate the effectiveness and efficiency of the program with respect to:

- adherence to the process guidelines as described above; and
- outcome - i.e., results of intervention.

CHAPTER IV: SPECIFIC ASSESSMENT GUIDELINES

Assessment is an important and extensive stage of practice in occupational therapy, having as its goal the recording, analysis and interpretation of the problem(s) presented. This assessment chapter includes a general discussion headed "Orientation", followed by an outline of the key assessment elements.

ORIENTATION

Assessment is the first stage of active involvement with a client and significant others involved in a problem. Occupational therapists generally assess individuals rather than families or groups. An initial assessment should precede implementation of a therapeutic program; reassessment should then occur at regular, defined intervals to ensure relevance to the client's needs.

As discussed in CHAPTER II: CONCEPTUAL FRAMEWORK, an occupational therapy assessment describes the functional status of an individual in his environment in terms of three areas of occupational performance (self-care, productivity, and leisure); and in four performance components (mental, physical, sociocultural and spiritual functioning). (For a specific example see Appendix C).

Occupational therapists tend to view function in terms of strengths and deficits in order to assess the individual and his ability to engage in his environment in a meaningful way. These strengths and deficits are considered through a lifespan approach in which human biology (eg. size, strength and medical limitations), lifestyle (eg. proportion of productivity to leisure or self-care, use of addictive subtances) and the environment are considered in the context of the individual's stage of life.

ASSESSMENT ELEMENTS

A formal assessment should include portions of the following specific elements.

1. INTERVIEW
2. RESEARCH OF OTHER SOURCES OF INFORMATION
3. ASSESSMENT OF TASK FUNCTIONING
4. CONCLUSIONS AND RECOMMENDATIONS
5. DOCUMENTATION OF THE ASSESSMENT

1. THE INTERVIEW

An assessment interview has three purposes:

(a) to initiate an interpersonal, therapeutic relationship with the individual;
(b) to clarify the goals of the assessment; and
(c) to gather information relevant to the presenting problem.

(a) The Interpersonal Therapeutic Relationship

In the initial interview, the therapist should attempt to establish rapport with the individual through therapeutic use of the self. It has been shown that the qualities required in a helping (therapeutic) relationship are: empathy, warmth, genuineness and nonjudgemental attitudes (Rogers, 1969; Carkhuff, 1969). These qualities must pervade the use of specific interview techniques such as questioning, paraphrasing and attending non-verbally.

The therapist should be conscious of the roles which the therapist and the individual are playing within the relationship. For example, initially the therapist may play a dominant, parental role with the individual in a dependent role. The therapist may then facilitate a change of roles to help the individual take on an independent, decision-making role, with the therapist filling a resource role.

In this relationship, the therapist should gain the trust of the client, particularly in adhering to the confidentiality agreed on between the two. Basic to developing trust is the client's informed consent to engage in this helping relationship. This relationship is the key element in the therapist's ability to motivate the individual. It allows the therapist to explore and understand the motivating factors unique to that individual which must be known before the individual takes action and addresses the present problem.

(b) Clarifying the Goals of the Assessment

The therapist should involve the client in the therapeutic process from the initial contact to the final termination of the services. Independence should be promoted by helping the client understand and assume responsibility for solving his own problems. The therapist should ensure that the client understands and participates in the process of assessment.

(c) Information Gathering

There are three types of information which should be gathered in an interview and from other sources:

(i) Demographic data:
name, age, address, employment, etc.

(ii) Relevant historical information:
personal history related to areas of occupational performance and performance components (See Figure 1);
developmental, family and medical history.

(iii) Current status and presenting problem:
This information can be gained through observation and questioning. The therapist should observe such criteria as appearance, mannerisms, attitudes, mood, affect, cognitive functions and behaviour.

Present functional status would then be considered under the same taxonomy used to determine past functional status. These include: four performance components; three areas of occupational performance; and environmental considerations (See Figure 1). Specific examples of activities for testing under each of these categories are listed in Appendix A.

2. RESEARCH OF OTHER SOURCES OF INFORMATION

Sources of information, other than data collected via interview and testing the client, should be reviewed.

Each service should define policies which outline the procedures required to respect confidentiality when gathering information from sources other than the client.

Sources may be:

(i) Interviews with persons significant to the client: family, friends, employer.
(ii) Review of test reports by others: review of psychological, physical, neurological, and other tests.
(iii) Review of past records: review of hospital, clinic, agency, personnel or other relevant records for which permission to release information has been granted by the client.

3. ASSESSMENT OF TASK FUNCTIONING

The most central element of assessment in occupational therapy is to observe and test performance in addition to discussing it in an interview. This is essential because the goal of occupational therapy is to encourage independence and satisfactory performance in all areas of daily functioning. More crucially, the uniqueness of occupational therapy is to focus on functioning during the assessment and intervention.

Some examples of occupational therapy assessment of task functioning are given below:

(a) Informal, unstructured, subjective, qualitative observation.

The therapist observes a person, with identified criteria in mind (concentration, relationships with others, general knowledge) while the latter is cooking a meal; driving a car; and/or playing table tennis.

(b) Formal, structured, objective, measureable, quantitative testing.

The client may be assessed for the number of steps which can be climbed to get to the second floor of the person's house.

Testing of functional skills may be quantified by giving performance a numerical rating, to be compared at given review intervals. Testing of personal care may involve observation of bathing, washing and toileting rated on a numerical scale. Testing may then be repeated for comparison of progress at regular intervals.

The therapist may administer such standardized tests as:

Minnesota Rate of Manipulation Tests
Marianne Frostig Development Test of Visual Perception
Harris-Goodenough Draw a Person Test
Southern California Sensory Integration Tests
Bay Area Functional Performance Evaluation.

4. CONCLUSIONS AND RECOMMENDATIONS

The therapist should analyze and integrate the data collected. Using the conceptual framework of occupational therapy, (the holistic approach, developmental approach, occupational performance model) the data and observations should be organized to formulate an impression and summary of the problem(s). The occupational therapy assessment should then indicate recommended action.

Occupational therapists may refer to other services for additional assessment information, the method of referral being determined by the agency, institution, or situation in which the therapist works.

5. DOCUMENTATION OF THE ASSESSMENT

Assessment information should be recorded within a time limit defined by the service. The assessment should be recorded as a document separate from the progress or other notes and should be circulated to the referring agent or source (e.g. the client's central file; a referring agency outside the service). Circulation of the assessment to others besides the referring agent should be completed only with the client's knowledge and consent.

The document should contain a summary of all information under appropriate headings in a format which is brief and easy to read. One example of headings used to record assessment information is given below:

demographic data
presenting problem
sources of information
summary of current status
relevant history
testing completed
conclusions and recommendations.

CHAPTER V: SPECIFIC PROGRAM PLANNING GUIDELINES

Program planning is a specific activity required to make intervention relevant to the problems and needs identified in the assessment. Planning of client programs should precede intervention, and be done after each review assessment (problems and needs change as intervention takes place). Planning should occur whether the therapeutic program goals are preventing, restoring or maintaining function. The program plan should:

- be based on an assessment of needs as outlined in Chapter IV;
- indicate the specific plan for occupational therapy, describing how occupational therapy services would be integrated with other services being received by the client; and
- involve the client in the preparation and implementation of the plan.

Further, a program plan should contain information separate from the assessment and intervention records. The information contained in the program plan is basically the same whether the plan is for an individual or a group of clients. In addition, this information may be classified under various headings outlined below. Informal plans should be recorded and communicated. Whether summarized or detailed, the following should be included.

1. FRAME OF REFERENCE

A frame of reference is a theoretical blueprint or a therapeutic philosophy within which program planning may occur. The frame selected depends on the situation, resources, and the therapist's education and experience. Some frames are as follows:

- occupational performance
- sensory integration
- neuro-developmental
- behavioural
- psychodynamic

2. GOALS AND OBJECTIVES

A goal should state the purpose of a program (e.g.- return the client to competitive employment). An objective should indicate specific action planned, conditions stated, and outcome expected. For example, an objective might be to increase work tolerance.

3. NEED FOR INDIVIDUAL OR GROUP INTERVENTION

The plan should indicate at what points in intervention the client will be seen individually or in groups. Some clients may receive one service, whereas other clients may receive multiple services with a mixture of individual and group intervention. The type of groups (expression, lifeskills, motivation, task, etc.) should be specified.

4. TIME AND FREQUENCY

The length of time and frequency of occurrence for sessions with clients should be stated (e.g. once daily for one hour; one afternoon per week).

5. PERSONNEL

The plan should indicate who will carry it out. The person(s) may be the same or different from the professional who completed the asssessment. Parts of the program may be carried out by specified persons other than the occupational therapist.

6. RECOMMENDED THERAPEUTIC ACTIVITIES

Activities chosen should reflect the frame of reference being used. The general activity areas, rather than the media, should be specified. Activities should be related to the areas in which there is dysfunction. For example, a therapist may use vocational activities for a tradesman. Implementation plans should indicate stages for the client to experience in reaching goals and objectives. If new knowledge and skills are involved, stages should facilitate learning (e.g. simple to complex activities in relevant situations).

7. RESOURCES

The therapist should indicate the specific equipment, supplies and facilities required to implement the program.

8. COST CONSIDERATIONS

In Canada, services within a health, social service or educational institution are generally provided without direct cost to the client. However, in community programs and to some extent in institutions, therapists should be aware of user fees when planning client programs. Therapists must consider costs incurred by clients and the institution in planning a therapeutic program. Such costs may be related to equipment, materials, support services, and transportation.

9. REVIEW OF CLIENT PROGRAM

The program plan should specify the frequency, type and method of review. For example, client functioning may be reassessed daily in an acute care program or monthly in a long-term care program, by having a client demonstrate the level of function in a variety of areas. (See Chapter IV)

A program plan may be summarized or detailed. The purpose of this chapter is to stress that a plan should be recorded for every type of therapeutic program. The plan should be a link between the assessment and implementation indicating a rationale for the therapist's actions.

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EXAMPLES OF INTERACTING ELEMENTS OF THE INDIVIDUAL IN A MODEL OF OCCUPATIONAL PERFORMANCE

(a) Areas Of Occupational Performance

Self-Care

- grooming
- hygiene
- toileting
- feeding
- dressing
- mobility
- bathing
- driving

Productivity

- play (children)
- school work
- paid work
- volunteer work
- homemaking

Leisure

- hobbies
- use of free time
- use of community resources
- pets
- cultural interests
- recreation and sport involvement
- clubs and groups
- entertainment and social involvement
- creative activities
- collecting activities
- nature interests
- games
- volunteering

(b) Performance Components

Mental

- cognitive (memory, orientation, concentration, intellect, insight, judgment, general knowledge)
- mood and affect (appropriateness, level)
- behaviour (appropriateness, control)
- perception (awareness of reality, visual perception)
- thought content (clarity, appropriateness, organization, compulsiveness)
- emotional defenses (e.g. denial, projection)
- reaction/adaptation to dysfunction
- body image
- volition in thought and behaviour

Physical

- range of motion
- strength and muscle tone of individual muscles or muscle groups, particularly as they apply to functional tasks, such as reaching, climbing
- coordination, balance, presence of involuntary movements (e.g. tremor, spasticity, etc.)
- endurance
- sensation (testing of functional limitations due to sensory disturbances in touch, pain, pressure, vision, hearing, taste, vibration, proprioception, kinesthesis and stereognosis)
- appearance (deformity, oedema, markings - particularly in terms of the functions they affect)
- pain (quality of pain, phantom pain, referred pain)

Sociocultural

- involvement in community
- family relationships
- friendships
- effect of client problems on relationships with family and others

Spiritual

- sense of purpose in life
- source of inner motivation
- presence of a set of beliefs and a value system

(c) Physical, Social And Cultural Environment:

In examining the person's environment, the therapist should consider a number of factors, some examples of which are given below.

Physical Environment

- wheelchair accessibility indoors/outdoors
- location of bedroom, bathroom, kitchen, living area (distance, stairs)
- type and condition of flooring for mobility, space, shape and distances for reaching clothing, kitchen goods, etc. (i.e. energy conservation features)
- transportation available

Social Environment

- relatives or significant others at home
- availability of assistance during day and/or night
- companionship available
- friends or other support persons

Cultural Environment (system of beliefs, ideals, customs and values)

interests of others in the household or friendship group
expectations regarding work, leadership in family, role, behaviour
activities requiring participation for acceptance
attitudes to sickness/disability
remedies and approaches for sickness/disability (i.e. local medicine)

ADMINISTRATIVE GUIDELINES FOR THE ESTABLISHMENT OF AN OCCUPATIONAL THERAPY SERVICE*

1. Obtain copies of the statement of philosophy, aims and objectives of employer.

2. Write a general statement of the philosophy, purpose and goals of occupational therapy which is congruent with 1.

3. Identify the characteristics and possible needs of the populations which may require occupational therapy services and quantify the need(s) as identified.

4. Set up an operating structure for occupational therapy services:

   (a) Identify areas of practice or service (e.g., paediatric, day hospital orthopaedic outpatient, hand clinic).

   (b) Estimate the staffing requirements, both professional and support for each service area.

   (c) Write job descriptions for these positions and define educational qualifications, experiential and special skills requirements.

   (d) Identify and quantify supplies and equipment, including safety and preventive maintenance routines required for services identified.

   (e) Identify secretarial/clerical support needs.

   (f) Identify space required to accommodate (a) to (e) above, considering:
      (i) location in relation to patient accommodation, other disciplines and related programs; and
      (ii) the special characteristics of the environment required by professional and support staff for a safe and efficient operation.

5. Establish directives for the delivery of specific occupational therapy services with this employer, to include:

   (a) A general statement of criteria for referral for service consistent with the philosophy of the agency. Write more detailed referral criteria for each of the identified areas of practice or service according to specific need.

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(b) The procedures to be followed for referral to occupational therapy services, proceeding from general statements relating to all referrals to specific statements relating to special referral categories (e.g., "standing orders", referrals to a multidisciplinary team of which the occupational therapist is a member, referrals from "out-of-house" physicians).

(c) General procedures for recording the receipt and disposition of referrals to occupational therapy.

(d) A general statement regarding priority for referrals received; the generation and management of waiting lists; guidelines for refusal and discontinuation of service, to assist staff in managing referral overload; inappropriate referrals and problem discharges.

(e) Statements relating to the criteria for discharge and follow-up procedures, post-discharge home visits, referrals to external agencies, etc.

(f) General procedures for documenting the occupational therapy process: recording of assessments, treatments, outcome, discharge and follow-up. Identify medical record charting requirements, which must meet legal and institutional requirements; and other records relating to the occupational therapy process that are required for ongoing treatment reference, teaching, program evaluation and research.

6. Write specific service goals and procedures for each area of practice identified. These should include:

(a) Recommended assessment and treatment protocols for the major diagnostic groups in that area (i.e., standard care plans).

(b) Procedures for the safety and security of patients and staff (e.g., approved transfer techniques, medical emergency).

(c) Procedures for obtaining equipment and support services for clients - orthotics, vocational assessment, nursing care at home.

(d) Directions for costing and billing for recoverable services including third party insurers.

7. Develop a series of general and specific statements relating to indirect service areas - e.g., clinical education, research, supportive activity programs ("diversional", "recreational"), adaptive equipment services to external individuals and organizations, sheltered workshop, outreach (home care, consultant) programs.

8. As the specific procedures are documented, an information system should be developed:

   (a) To identify and quantify staff activity (use Statistics Canada's Canadian Schedule of Unit Values for Occupational Therapy, 1979 as a base if this is a required reporting system).

   (b) To identify the population characteristics of those referred to and receiving occupational therapy.

   (c) From (a) and (b) to develop a data base for planning resource allocation and development (staff/patient ratio, new and expanded programs, program changes), program evaluation, staff workload in direct/indirect, clinical education and continuing education.

9. Develop program evaluation mechanisms for each major activity defined, e.g., client record audits, validation of assessment procedures and their correct use and implementation (measurement), peer review of treatment process both current and retrospectively, outcome studies.

   (a) These evaluations should be built into the protocol and recording of each major activity area.

   (b) Program evaluation activities reports should be generated regularly for management and should include provisions for revision and re-evaluation of procedures.

   (c) Continuing education and inservice programs should be generated using information from (b) to ensure staff skills and procedures deficits are addressed and that staff maintain currency with scientific advances.

   (d) Identify areas requiring clinical investigation and research.

CASE ILLUSTRATION OF THE OCCUPATIONAL THERAPY PROCESS

REFERRAL

Name of Referral Source

DATE OF REFERRAL:
DATE OF RECEIPT:
RECEIVER OF REFERRAL:

NAME:	John Jones
AGE:	45 years
OCCUPATION:	unemployed, formerly a carpenter
ADDRESS:	home town, province (post office or street address)
PHONE:	home number
CONTACT PERSON:	daughter's name, address, phone
HOME SITUATION:	widowed in last three months, lives with daughter, receiving social assistance
PROBLEM IDENTIFIED FOR REFERRAL:	In last month, excessively sullen, angry and resistant to daughter at home, refusing to attempt to be independent in self-care or assisting with housework. Right, above-knee amputee three years ago, occasionally violent and threatening suicide.
REQUEST TO OCCUPATIONAL THERAPY:	Assessment of emotional status and level of physical functioning; therapeutic program to improve both emotional and physical functioning.

_____
SIGNATURE OF REFERRAL AGENT

ASSESSMENT

Refer to Chapter IV for recommended guidelines for assessment.

1. THE INTERVIEW

(a) Interpersonal Therapeutic Relationship

The therapist actively indicates empathy, a non-judgmental attitude and acceptance of the client's anger and other emotions. The therapist's genuineness in attempting to understand the client's motivating forces must be evident.

(b) Clarifying the Purpose of Assessment

The purpose of the assessment is to explore Mr. Jones' self image and meaning in life as a physically disabled, unemployed male. A review will be done of his current and potential physical function. Discussion might occur about the loss of his wife.

(c) Information Gathering

(i) Demographic Data
(ii) Historical Information: client reactions to past dysfunctions; family roles and relationships; sense of meaning in life;
(iii) Current status and presenting problem in the following areas.

2. AREAS OF OCCUPATIONAL PERFORMANCE

Self-Care	physical independence in dressing, bathing, toileting, getting into bed, use of wheelchair or ambulatory aids, ability to negotiate stairs, car driving, dressing, making a meal, emotional attitude to independence; and daughter's perception of his independance.
Productivity	physical skills for possible future employment; attitude, adaptation, behaviour and emotional control of anger; ability to have constructive relationship with co-workers.
Leisure	ability to participate in leisure activities; motivation and attitude to adjusting to leisure activities.

3. PERFORMANCE COMPONENTS

Physical	range of motion of the stump, the other leg, lumbar spine (related to ambulation);
	range of motion of upper extremities, neck, upper back (if using ambulation aids such as crutches);
	strength of stump, other leg, upper extremities (related to ambulatory function);
	sensory disturbances in the stump, particularly phantom pain, hypersensitivity to touch and pressure;
	appearance of the stump (oedema, skin);
	sitting and standing balance;
	ambulatory endurance.
Mental	body image and self concept as an amputee;
	adaptation to amputation: resolution of loss/grief of the limb and the function;
	coping skills to deal with physical changes and limitations;
	current mood and affect;
	resolution of loss of wife with implications for his own future;
	personality characteristics as shown in past behaviour, past history of depression and its resolution;
	coping skills to deal with physical changes and limitations.
SocioCultural	relationship between father and daughter;
	community involvement;
	friendships;
	attitudes to a non-employed disabled man.

Spiritual	vision of self in future: what purpose in life can he have in his physical condition? what set of beliefs does he have to help him to feel worthwhile? concept of meaning in life and death (explore factors related to threatened suicide; source of anomie.

4. RESEARCH OF OTHER SOURCES OF INFORMATION

It would be helpful to interview the daughter to clarify her role and her relationship with her father.

Past psychological testing may help to reveal personality factors related to adjustment to the disability. Review of past and present records by nurses, physicians, and physiotherapists may help to clarify physical and psychological status.

5. ASSESSMENT OF TASK FUNCTIONING

The areas of occupational performance and performance components would also be assessed through task functioning. The following types of testing may be utilized.

Informal Testing:	Observation of behaviour, attitudes, skills in various activities and situations related to selfcare, employment and leisure. Projective testing to clarify emotional status and motivational forces.
Formal Testing:	Range of motion and muscle strength of the stump. Pre-vocational assessment related to future employment potential in terms of physical skills, emotional status and work habits.

6. CONCLUSIONS AND RECOMMENDATIONS

The information should be summarized and reviewed with the client

- for accuracy;
- as a therapeutic means of involving the client in defining the problem, in understanding the factors underlying the problem, and in highlighting the factors which must be changed to resolve the problem.

The key problem with this 45-year-old gentleman appears to be uncontrolled, demanding, aggressive behaviour, due to feelings of anomie and uselessness. The contributing factors are:

the man's dependent, immature personality;
major losses;
lack of meaning in life with no motivating factors to define a future;
lack of mobility brought on by infrequent use of prosthesis;
guilt and dependence on the daughter, making her unable to cope constructively with her father's behaviour.

In this case, recommendations might be that:

(a) the client participate in an occupational therapy program oriented to both teaching increased physical function and dealing with emotional issues such as loss of wife and limb and other functions; addressing issue of anomie;

(b) the client be linked with other amputees who have experienced but overcome the adjustment to the disability;

(c) the daughter be involved in the client's activity program;

(d) occupational therapy programs be centred both in a rehabilitation centre, and at home and the community to aid in adjustment;

(e) possible referral for more intensive psychotherapy; and physiotherapy if reeducation of ambulation required.

7. DOCUMENTATION OF THE ASSESSMENT

Assessment information might be listed under headings for the four performance components and the three areas of occupational performance. It may be recorded as a written summary, a list, a checkoff form.

PROGRAM PLANNING

Formats for recording program plans can vary; however, each plan should contain the information outlined in Chapter V: PROGRAM PLANNING GUIDELINES. As well, the program plan should have goals and objectives articulated from the recommendations suggested in the assessment, numerous goals and documented objectives. One goal, from the client's view, is outlined in a sample plan below:

S A M P L E P L A N

1. FRAME OF REFERENCE -
   The Occupational Performance Model of Practice will be used.

2. GOALS AND OBJECTIVES -

Goals

The client and therapist will explore the client's current emotional status by encouraging a constructive, open expression of his emotions through activity.

Objectives

(Many objectives could be derived from this one goal; one client's objective is outlined).
The client will be able to express emotions related to the loss of his wife.

3. TYPE OF INTERVENTION AND TIME AND FREQUENCY
and
4. To be seen individually, one hour daily for two weeks followed by a specific reassessment of emotional status.

5. PERSONNEL

   The therapist might initially assume a role as understanding nurturer and then encourage the client to become more emotionally responsible and mature.

6. THERAPEUTIC ACTIVITY

   Therapeutic use of activity will stimulate thought, introspection and expression of emotions.

   Discussion centred around photo albums and mementos.

Small carpentry project which symbolizes some facet of past experience and relationship with his wife (possibly something she would have liked him to make for her); this project might also serve another goal in which future vocational and leisure interests could be derived from past skills.

7. RESOURCES

Appropriate woodworking activities and a quiet area are required.

8. COST

While the client is a hospital inpatient there is no cost directly charged to him; if he is followed after discharge in a community program, there may be a user fee depending on the source of the community service.

9. REVIEW OF CLIENT PROGRAM

The effectiveness of the occupational therapy program should be evaluated (at regular intervals during the program) and at the end of the client's program.

Factors such as the involvement of other services and the therapeutic effect of the hospital milieu will have to be considered.